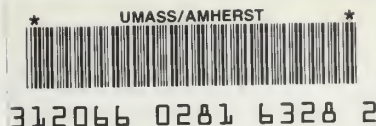


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## Finance Working Group: Initial Findings on Hospitals

Draft 6-12-00, 11:30 am

GOVERNMENT DOCUMENTS  
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### OVERVIEW

The principal findings of the Finance Working Group with respect to hospitals are:

- The financial condition of Massachusetts hospitals has generally deteriorated over the last several years to what are among the lowest operating results in the country. (See Figures 1 and 2)
- The significant cause of the deterioration appears to be that hospital costs have outstripped the limited growth in revenues. Hospital costs had been growing slowly for several years, and grew more rapidly in the last few years. (See Figure 3)
- Hospital revenue growth was curtailed by cutbacks in Medicare payment rates that resulted from passage of the federal 1997 Balanced Budget Act (BBA). Massachusetts hospitals that have skilled nursing beds, home health services or graduate medical education programs were particularly hard hit by the BBA.

The above trends in hospital costs and revenues have been true for hospitals throughout the country, but have affected Massachusetts hospitals more severely because the state's hospitals had lower profit margins, weaker cash positions and higher debt levels before these negative trends began. (See Figures 4 through 7) Massachusetts hospitals have had low margins relative to the rest of the country for many years, largely as a result of rate regulation in the 1970's and 80's.

### OPTIONS FOR STATE ACTION

Faced with the deteriorating trends listed above and because some hospitals could be forced to close in the near future, the state could adopt one of the following strategies:

#### A. The "Hands Off Approach"

Massachusetts is generally considered to have some of the best hospitals in the world. But it is also among the most competitive hospital environments, particularly in urban areas. There are indications that, if left alone, financial conditions will improve for hospitals in the state. Improvements would be spotty, however - some hospitals would continue to have serious problems, and some areas of the state might develop access problems, with others becoming less competitive.

Without intervention, it is likely that hospitals will attempt to increase their revenues primarily through increasing rates to all privately insured patients. With the high proportion of managed



care patients in Massachusetts and the size of the financial problem, it is questionable whether the revenue finally generated from these higher rates will be sufficient to solve all of the financial issues. Hospitals will be faced with difficult choices to bring costs (and services) within constrained revenue growth.

## B. The "Intervention Approach"

State intervention can take one of three forms:

1. Offering general assistance to most hospitals through significant Medicaid rate increases.

This, the least intrusive state action, would provide added funds to most of the state's hospitals. It would have the greatest impact on those institutions with the largest Medicaid caseload, which are not always the institutions in the most serious financial position. This option assumes that the current cost levels are reasonable and that only additional revenues are needed. This assumption is not accepted by all, as Massachusetts does have the highest per capita hospital and medical spending levels in the country. These higher spending levels can be explained by a number of factors, including the greater proportion of teaching hospitals and the relatively greater use by Massachusetts residents of outpatient specialty care in hospital settings. Such an explanation is not necessarily a justification for the structure of the state medical system that generates this greater use of the most expensive facilities and services. Whether costs and utilization levels are justified or not, the state is faced with the dilemma of deciding whether to set Medicaid payment levels in a way that tries to encourage that services be provided in the lowest-cost setting appropriate, or whether to set payment levels more directly related to the cost of care settings actually used.

2. Providing financial assistance to a limited number of financially distressed institutions.

Under this option the state would need to create the capacity to assess the financial condition of each hospital and establish criteria to identify institutions that merit financial help. Such an effort would need to include development of the capacity to understand and monitor the health care system of the state and to assess the needs of the state's population. The state would need to determine the level of funding for needed for this kind of analysis and assistance, and how long help should be provided. Such an undertaking would require an expansion in the state's analytical capacity and substantial state expenditures given the magnitude of the problem. Past efforts by the state with such health planning met with mixed results.

3. State taking responsibility for the financial conditions of hospitals by creating a state Rate Setting System.

This, the most ambitious of the intervention options, would require all of the activities listed in #2 plus the long-term commitment of the state to take responsibility for the financial viability of its hospital system. It would also require the "buy-in" of all the payers, private and public (a



Medicare waiver could be requested or Medicare could be left out of the system). The state's experience with rate setting has also had mixed results.

## **OVERALL RECOMMENDATION**

The consensus of the working group is that neither approach, in the extreme, is appropriate. There is general agreement that some level of intervention is warranted and that it should be limited and strategic. However, the group believes that it does not yet know enough to craft such an intervention strategy. Therefore, we suggest that the state immediately enhance its capacity to monitor the system, to recommend a strategic intervention approach, and to engage in contingency planning for a health care safety net system.

Our assessment of the current state of Massachusetts hospitals and of actions that might be taken has been handicapped by the lack of data and by contradictory data analysis around critical points such as appropriate hospital cost levels. This conflict around credible data makes it difficult to assess corrective action and may lead to no action or inappropriate action. Therefore, we recommend that action be taken to develop credible and consistent data analysis that can be used to make informed decisions.

In essence the working group is recommending a "Watchful Waiting" approach. In recommending this approach the group was mindful that the health care market leaves some areas more exposed to instability than others. If the state elects to take a "watchful waiting" approach, it should monitor closely those areas that are likely to experience particular difficulty during times of instability. Examples of areas to monitor regularly include:

- The near-poor - monitor access to health care and coverage for those not covered by Medicaid, who cannot easily afford their own insurance.
- Geographically isolated pockets - monitor access to hospital and other kinds of care for isolated populations.
- Teaching Capital Assets - monitor the actual and reputational assets of our medical teaching enterprise for signs of decline.

Even signs of trouble in these areas may not lead inevitably to intervention, and what type of intervention might be appropriate is not yet clear. For example, we may be able to tolerate a reduction in the size of our medical teaching establishment, but we would be concerned about a decline in the reputation of the state for excellence in patient care, medical education and biomedical research.

## **FURTHER FINDINGS**

Although we need to expand our capacity to analyze and monitor the system, we can at this point state the following tentative conclusions. These findings describe the acute hospital industry as a



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<https://archive.org/details/initialfindings00mass>

whole; individual facilities' situations vary. For example, while operating margins for the industry are negative, some institutions are showing improvement, and a minority have operating profits. (See Figures 8 and 9)

#### Hospitals' Financial Condition:

- The Massachusetts health care marketplace has been tough and competitive, and has driven private managed care payment levels to hospitals below average costs. With managed care representing 20% or more of hospital revenue, these rates can no longer be set at marginal cost rates. (See Figures 10 and 11)
- Medicare payments provided positive margins on inpatient care for some time, particularly for teaching hospitals, but margins decreased markedly with the implementation of the Balanced Budget Act of 1997. Medicare outpatient rates have traditionally been below hospital costs and the new Medicare outpatient payment system is not expected to markedly change this situation.
- Medicaid payment levels similarly reflect rates of payment that are less than a hospital's cost, with payments for inpatient at approximately 92% of costs, but payment for outpatient services at approximately 66% of costs (Division of Medical Assistance, 1998 data).
- Over the last decade, Massachusetts hospitals experienced a shift in payer mix, characterized by a decrease in the percentage of patients covered by indemnity insurance (which paid well), and an increase in the percentage of patients covered by managed care plans (which paid less well). (See Figures 12 and 13) This shift was initially not a problem because of relatively high Medicare payments. With the decline in Medicare payments in the last two years and continued low rates from private managed care patients, hospitals experienced serious financial reversals.
- Massachusetts' Medicaid waiver program, MassHealth, has greatly increased the number of people covered by the Medicaid program. (See Figure 14) This increase in market share, coupled with the high proportion of managed care, means that major portions of the market are controlled by payers who traditionally have paid prices allowing little or no margin for hospitals. In other waiver states with similar Medicaid payment-to-cost ratios, indemnity payers that pay at higher levels are a greater portion of the market, thus allowing hospitals in those states to recoup Medicaid shortfalls.

#### Hospital System Cost Structure:

- Massachusetts hospitals did make major efforts to reduce excess capacity and expenses in the middle 1990's, and hospital inpatient utilization rates, which had been higher in the state, have now reached national averages. (See Figures 15 through 17) In the last few years, hospital costs began to rise, with salaries and supply costs the primary drivers. (See Figure 18) This trend is also reflected nationally.



- Vertical integration generally has not yielded the efficiencies and leverage that was expected. For example, it is estimated that Massachusetts hospitals lost between \$200-300 million from physician practice acquisitions. Horizontal integration and expansion have also contributed to financial losses.
- In comparison with other states and with national averages, per capita expenditures for hospital care in Massachusetts exceed those in most other states and for the nation as a whole. A portion of the difference can be explained by the higher cost of labor in this area and care provided to out-of-state residents. The major difference, however, is the result of the greater utilization of teaching hospitals, particularly their outpatient care. (See Figure 19)
- Because Massachusetts has a higher proportion of teaching hospitals, teaching hospitals are used more frequently in Massachusetts than on average nationally. Teaching hospitals are generally more costly on a unit cost basis than community hospitals. (See Figures 20 and 21) The casemix (a measure of the severity of patient conditions being treated) at Massachusetts teaching hospitals is similar to the national average teaching hospital casemix, and casemix at Massachusetts community hospitals is much lower than the national average community hospital casemix. (See Figure 22) These differences reflect the greater use of teaching hospitals in the state for conditions treated in community hospitals in other states.
- Hospital outpatient department utilization in Massachusetts exceeds national figures by approximately 32%. (American Hospital Association statistics)

If we accept these differential utilization patterns, most of the differences in spending between the state and national averages disappear, but the questions remain whether these differences are appropriate, and whether in the long run either our private or public payment systems will be willing to support the higher costs these patterns generate.

Massachusetts, as much and more than any state in the country, benefits from the quality of care and from the economic draw provided by academic medical centers. (See Figures 23 and 24) This is particularly true in Boston, Worcester and Springfield where teaching hospitals are the principal providers of health care. With most payers, public and private, unwilling to pay the “full extra costs” associated with providing care in a teaching hospital, the ability to afford and maintain the current system is a real and growing problem. At the same time, we are what we are – we cannot, and most Massachusetts residents do not want to, substantially replace teaching hospitals with community providers. But the system could encourage some movement of services to alternative (and lower cost) settings. Such a change would only generate savings if we correspondingly reduce our teaching hospital capacity. Some group members are not optimistic about our ability to change practice patterns, particularly in the short run. This situation could be worsened by the reduced influence of managed care on the decisions of patients and physicians. These issues will be addressed in the insurance (managed care) discussions.



**Figure 1:**

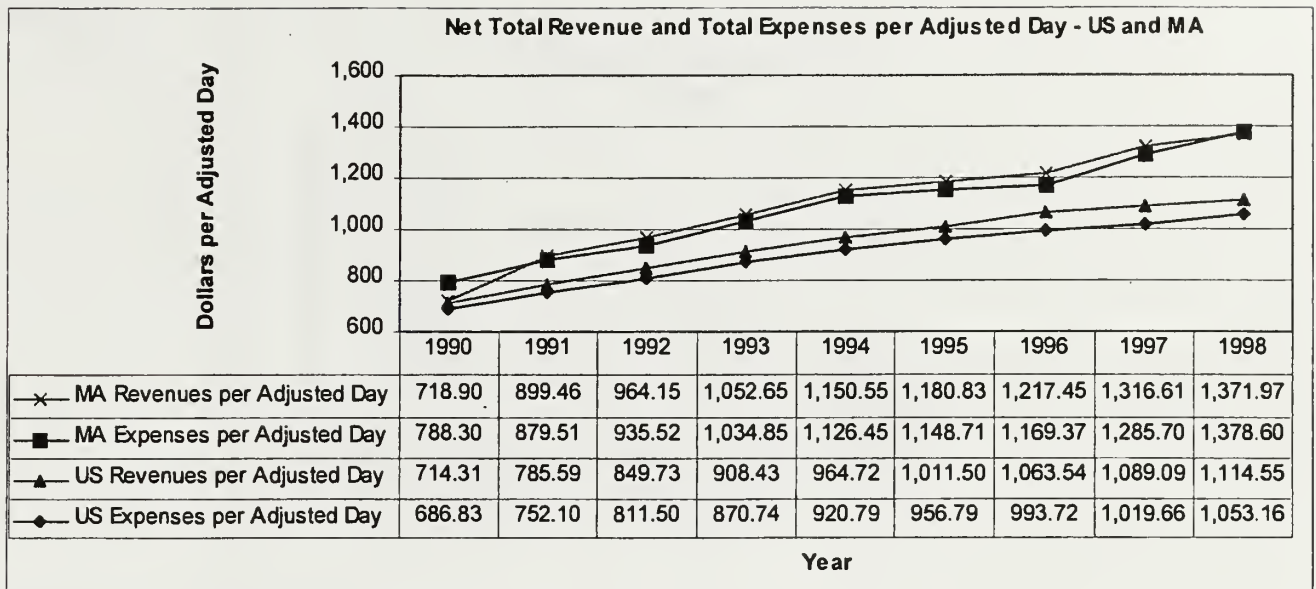
1998 hospital profit margins: All over the map

State	Total Profit Margin (%)	State	Total Profit Margin (%)
Alabama	4.5	Montana	9.7
Alaska	11.9	Nebraska	10.9
Arizona	7.2	Nevada	7.1
Arkansas	6.9	New Hampshire	6.9
California	4.2	New Jersey	0.7
Connecticut	8.8	New Mexico	9.7
Delaware	4.0	New York	1.1
District of Columbia	2.4	North Carolina	10.5
Florida	7.9	North Dakota	6.7
Georgia	10.9	Ohio	4.7
Hawaii	2.3	Oklahoma	4.4
Idaho	11.9	Oregon	6.7
Illinois	7.0	Pennsylvania	3.4
Indiana	8.6	Rhode Island	5.0
Iowa	7.1	South Carolina	8.0
Kansas	8.9	South Dakota	6.0
Kentucky	6.6	Tennessee	9.5
Louisiana	5.9	Texas	8.4
Maine	8.4	Utah	7.4
Maryland	4.6	Vermont	2.6
<b>Massachusetts</b>	<b>(.02)</b>	Virginia	9.4
Michigan	6.0	Washington	4.4
Minnesota	6.7	West Virginia	5.9
Mississippi	6.0	Wisconsin	6.8
Missouri	6.3	Wyoming	10.7

Sources: Modern Healthcare, April 10, 2000; AHA Hospital Statistics 2000

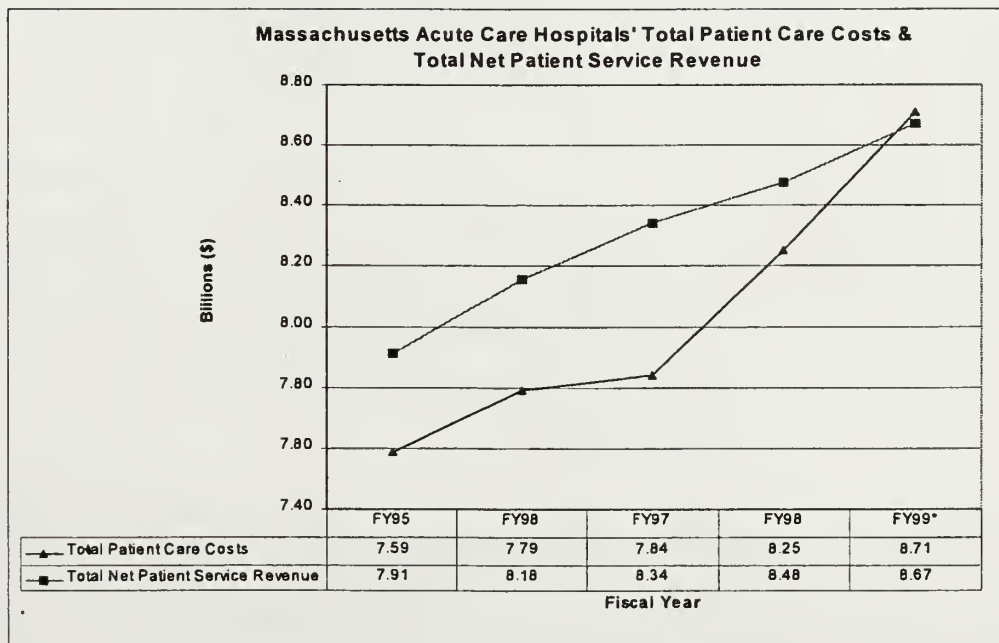
- Profit Margins in Massachusetts are the lowest in the country.



**Figure 2:**

Source: American Hospital Association, *Hospital Statistics*, 1991/92 – 2000.

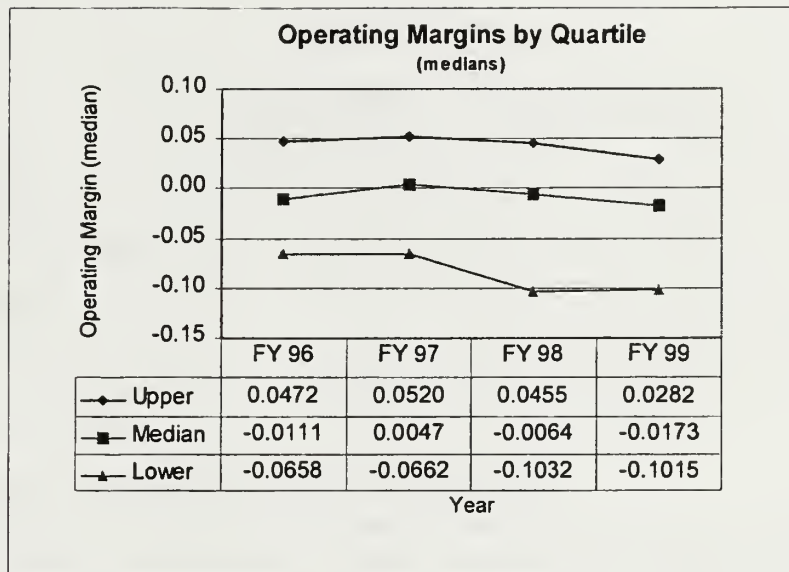
- Massachusetts hospital revenues and expenses have been increasing slightly faster than the national average. Unlike the national trend, Massachusetts hospital expenses appear to be increasing more sharply than revenues.
- Hospital = all non-federal, short-term general and other special hospitals, whose facilities and services are available to the public.
- Expenses = Patient Service expenses plus all other expenses for the reporting period.
- Revenue = Net patient service revenue, including contributions, endowment revenue, government grants, and all other payments not made on behalf of individual patients.
- Adjusted Day = [outpatient visits\*(outpatient revenue per outpatient visit/inpatient revenue per inpatient day)]+inpatient days.
- 1996 calculations for MA expenses per Adjusted Day and MA Revenues per Adjusted Day include a projected value for adjusted patient days.

**Figure 3:**

Source: DHC403 Cost Reports

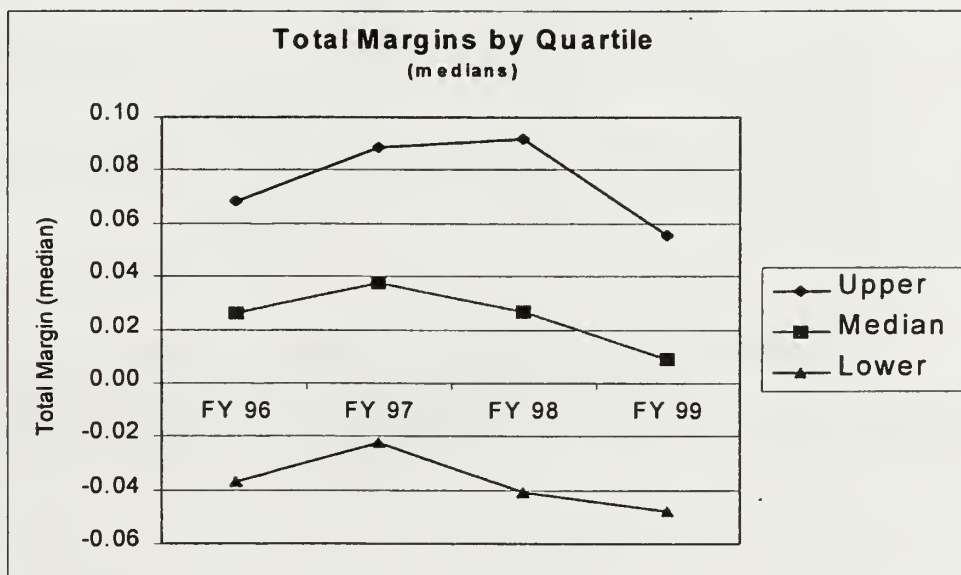
- Total patient care costs in Massachusetts are increasingly more rapidly than patient service revenue. Total industry costs exceeded total industry revenues in FY 99.



**Figure 4:**

Source: DHC403 Cost Reports

- This graph shows the trend in operating margins for the best off, middle, and worst off hospitals. Margins for all the groups declined in FY 98, and margins for the top two groups of hospitals declined again in FY 99, while the worst off group remained stable in FY 99.
- The top line represents the median operating margin of the top 25% of Massachusetts acute care hospitals. The middle line is median of all hospitals. The bottom line is the median of the 25% of hospitals with the worst margins. Operating margin is operating revenue less operating costs over total revenues.

**Figure 5:**

Source: DHC403 Cost Reports

- This graph shows the trend in total margins for the best off, middle, and worst off hospitals. Margins for all the groups declined in FY 98 and FY 99.
- The top line represents the median total margin of the top 25% of Massachusetts acute care hospitals. The middle line is median of all hospitals. The bottom line is the median of the 25% of hospitals with the worst margins. Total margin is operating and non-operating revenue less operating and non-operating costs over total revenues.



Figure 6:

Liquidity Ratios						
	Current Ratio		Days Cash on Hand		Days to A/R	
	FY97	FY98	FY97	FY98	FY97	FY98
Teaching Hospitals	1.60	1.46	13.91	3.84	59.13	76.35
%Change		-8.78%		-72.39%		29.12%
Community Hospitals	1.58	1.52	18.33	16.01	60.05	60.40
%Change		-3.55%		-12.67%		0.58%

Source: DHCFP403 Cost Reports

- Teaching hospitals have more serious problems with liquidity.
- While the current ratio is adequate for both, teaching hospitals have only an average of 3 days of cash for expenses on hand versus community hospitals, which have an average of 16 days of cash on hand.
- Teaching hospitals take longer to collect accounts receivable than community hospitals, and this number is growing significantly faster from year to year.

Figure 7:

Debt Structure Ratios						
	Equity Financing		Total Debt to Assets		Debt Service Coverage	
	FY97	FY98	FY97	FY98	FY97	FY98
Teaching Hospitals	0.392	0.361	0.608	0.639	4.09	3.09
%Change		-7.97%		5.14%		-24.42%
Community Hospitals	0.419	0.414	0.581	0.586	1.15	(0.18)
%Change		-0.99%		0.71%		-115.85%

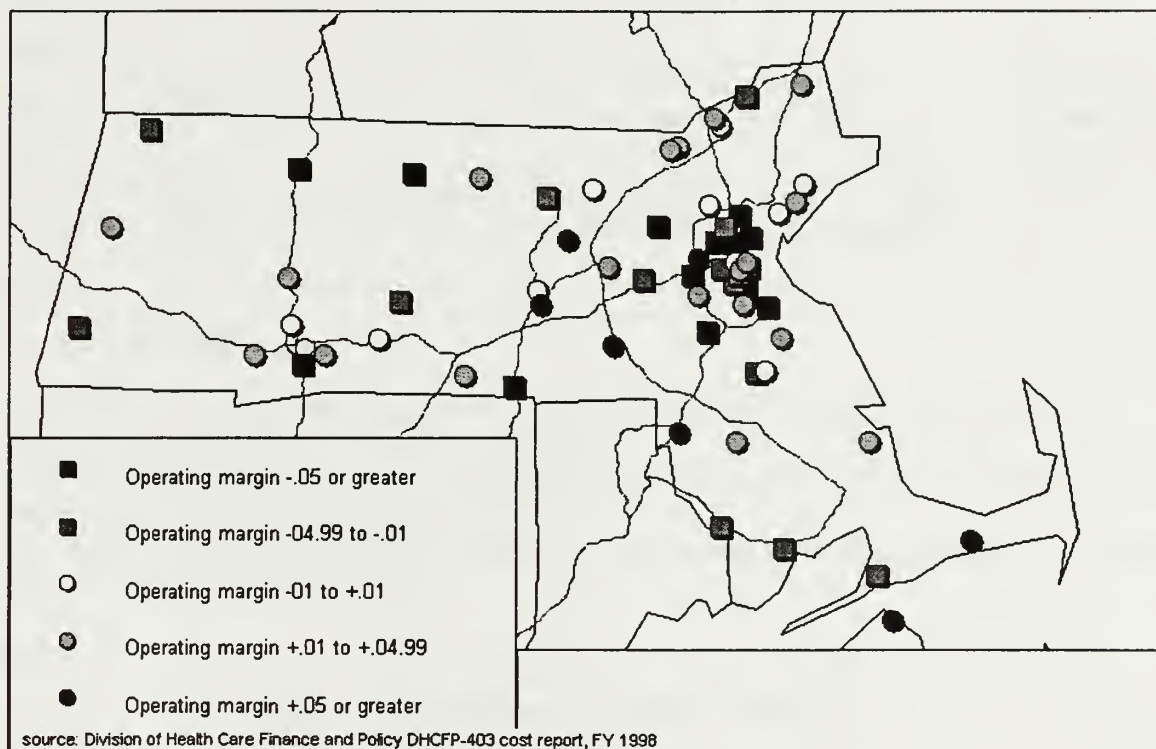
Source: DHCFP403 Cost Reports

- Teaching hospitals have more debt financing than community hospitals.
- Debt financing for both has been increasing over the past year.
- Even with more debt, teaching hospitals had adequate cash to cover their obligations, while community hospitals fell short in 1998.



Figure 8:

## Hospital Operating Margins - FY 98

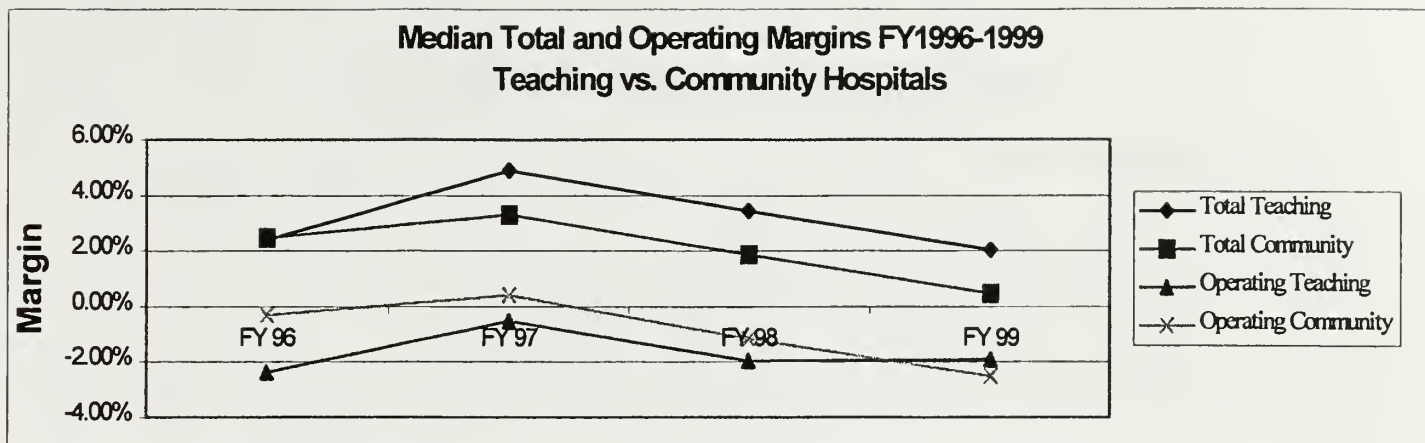


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- While operating margins for the hospital industry as a whole are negative, there is considerable variation among individual facilities.



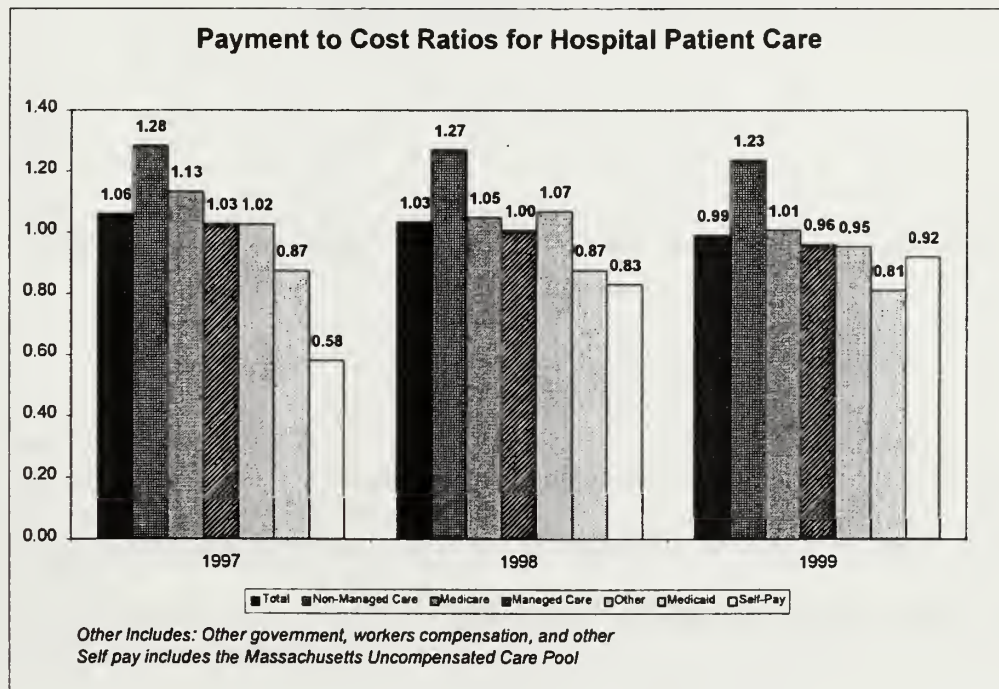
• **Figure 9:**



Source: DHCFP403 Cost Reports

- Since 1997, the median total margin and the median operating margin for both teaching and community hospitals have been steadily declining.
- Teaching hospitals' median operating margin in all four years studied; while community hospitals' operating margins were only positive in FY 97.
- The median total margin (includes operating and non-operating revenue) for community hospitals was only slightly positive in FY 99.

**Figure 10:**



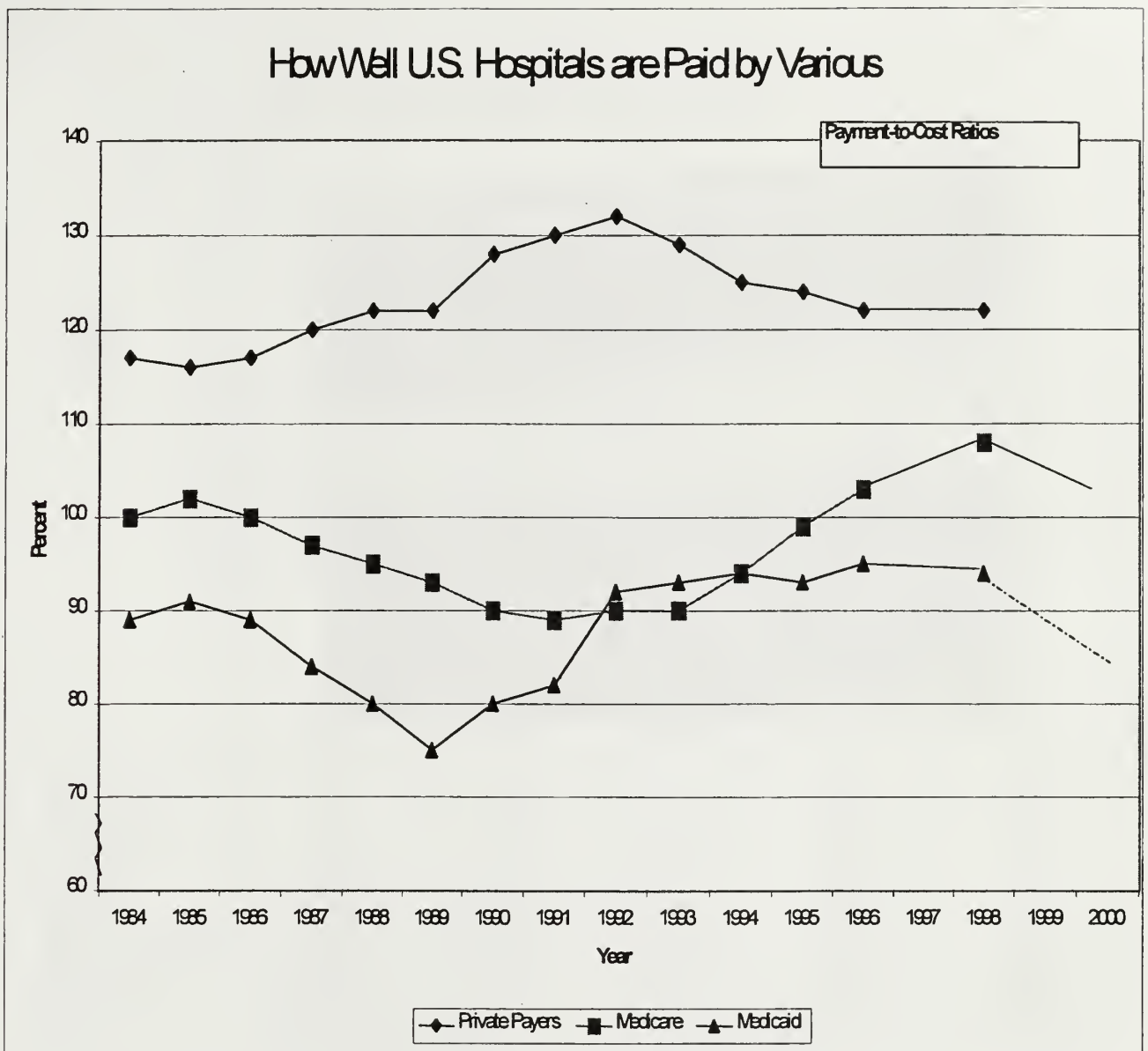
Source: DHCFP403 Cost Reports

NOTE: 99 data is as filed. Ratios may increase after auditors have reviewed data filings.

- Since 1997, the total payment to cost ratio for Massachusetts acute care hospitals has decreased from \$1.06 of revenue for every dollar of cost to \$.99. Payment levels from all payers have decreased relative to increasing costs. Payments from managed care payers fell below 1.0 in FY 99. The increase in self-pay payment levels may be due to fully funding the Uncompensated Care Pool, as well as to an increase in the number of international patients.



Figure 11:

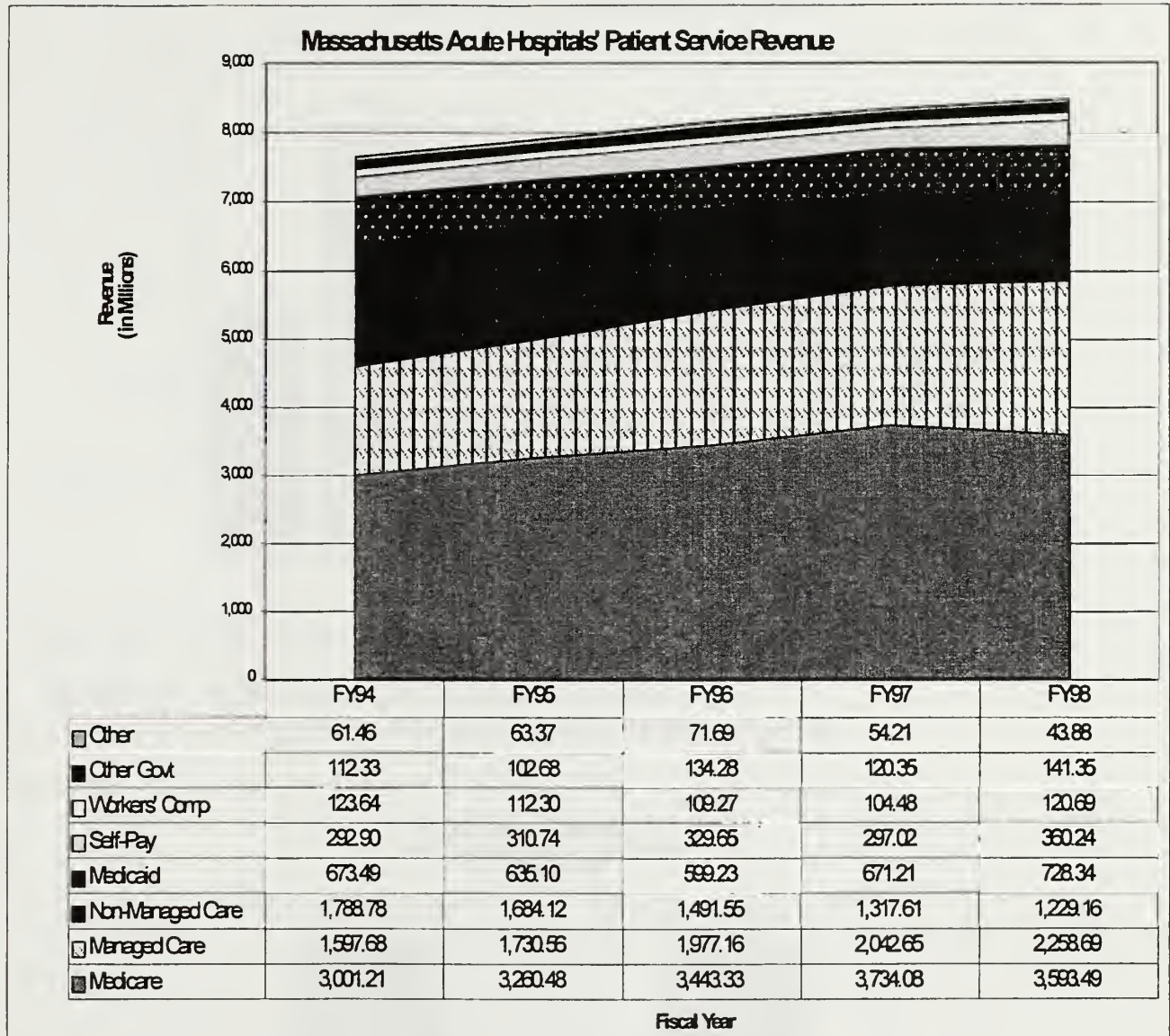


Source: Stuart Altman, Medicare Payment Advisory Commission, Annual Survey of Hospitals

- Medicaid payment rates to U.S. hospitals have averaged below cost for all 15 years studied, and averaged about 93% of cost for most of the 90s.
- Medicare payment rates were below cost from 1987 through 1995, but grew quickly from 1996 through 1998.
- Private payers have consistently paid well above cost, and considerably higher rates than public payers for all 15 years studied.



Figure 12:

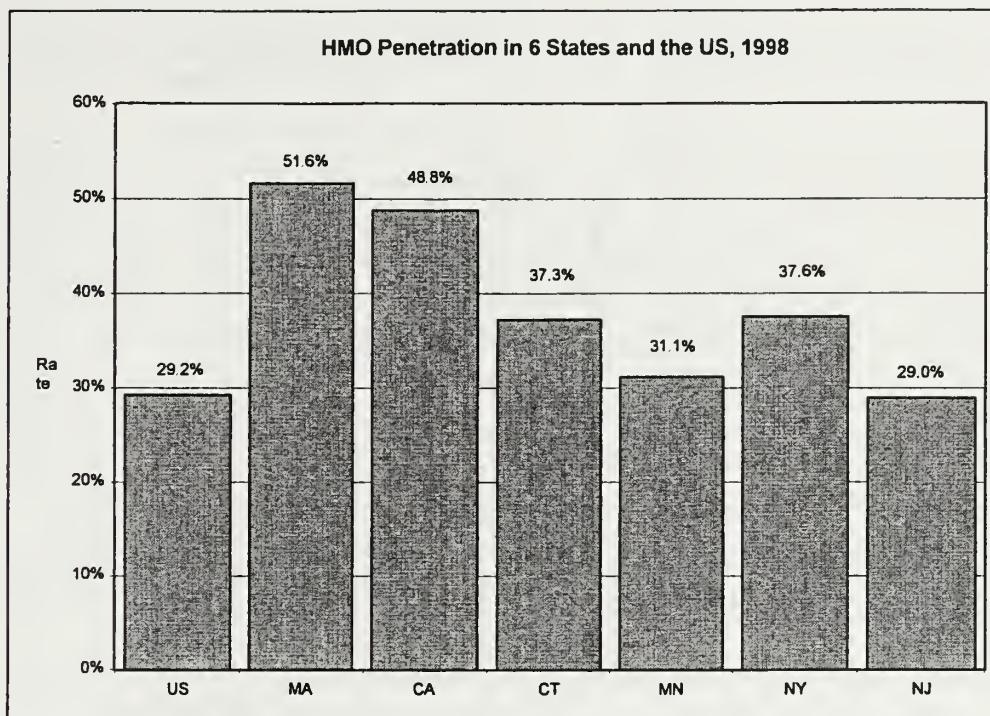


Source: DHCFP 403 Cost Reports

- Managed care revenues surpassed non-managed care revenues in FY 95, and have continued to increase.
- The early effects of the MassHealth expansion can be seen in FY 97 and FY 98.
- Total Patient Service Revenue: FY94 = \$7.65B, FY95 = \$7.90B, FY96 = \$8.16B, FY97 = \$8.34B, FY98 = \$8.48B



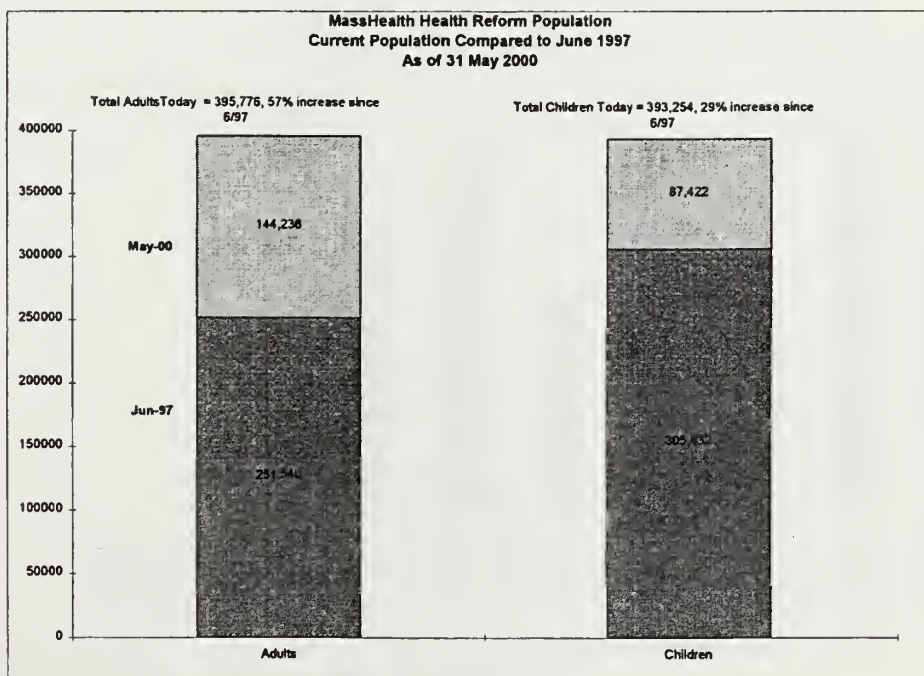
Figure 13:



Source: Reforming the Health Care System: State Profiles 1999, AARP © 1999

- Massachusetts has the highest HMO penetration rate in the country.
- Also included in the graph are other states with high rates of managed care.

Figure 14:

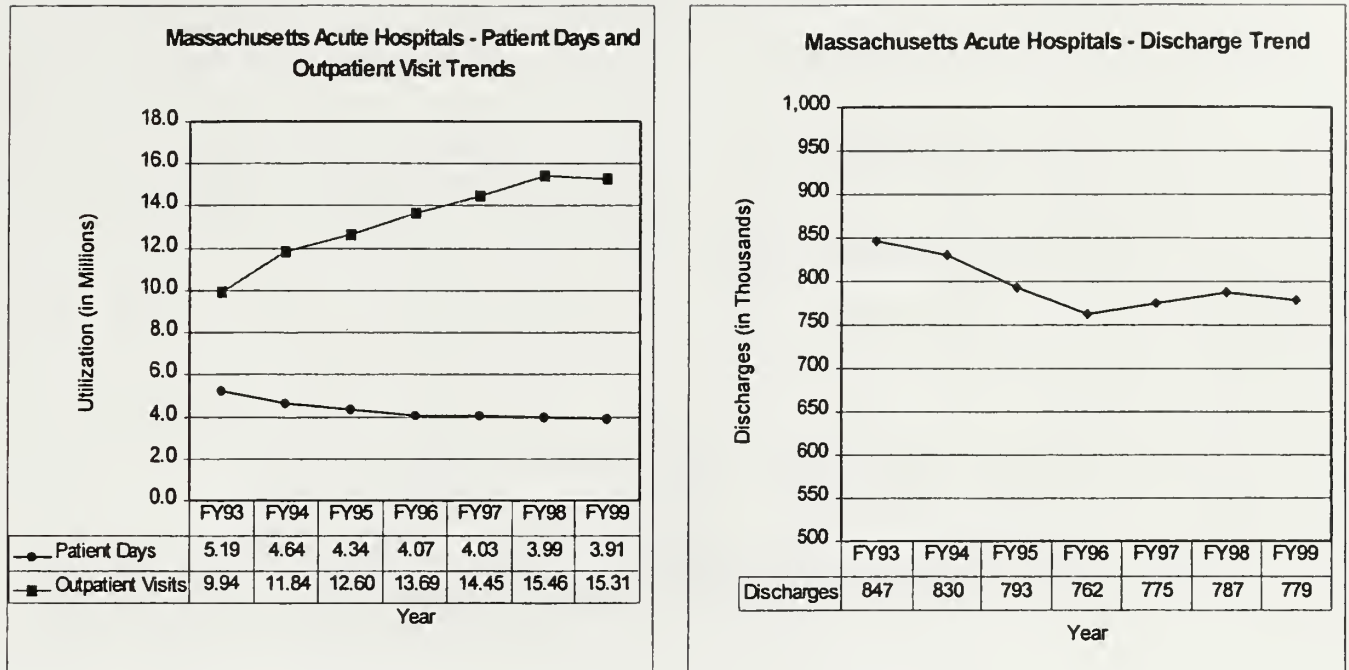


Source: Massachusetts Division of Medical Assistance

- The total number of people enrolled in MassHealth has increased dramatically since 1997; the increase in adult enrollment is nearly twice the increase in child enrollment.



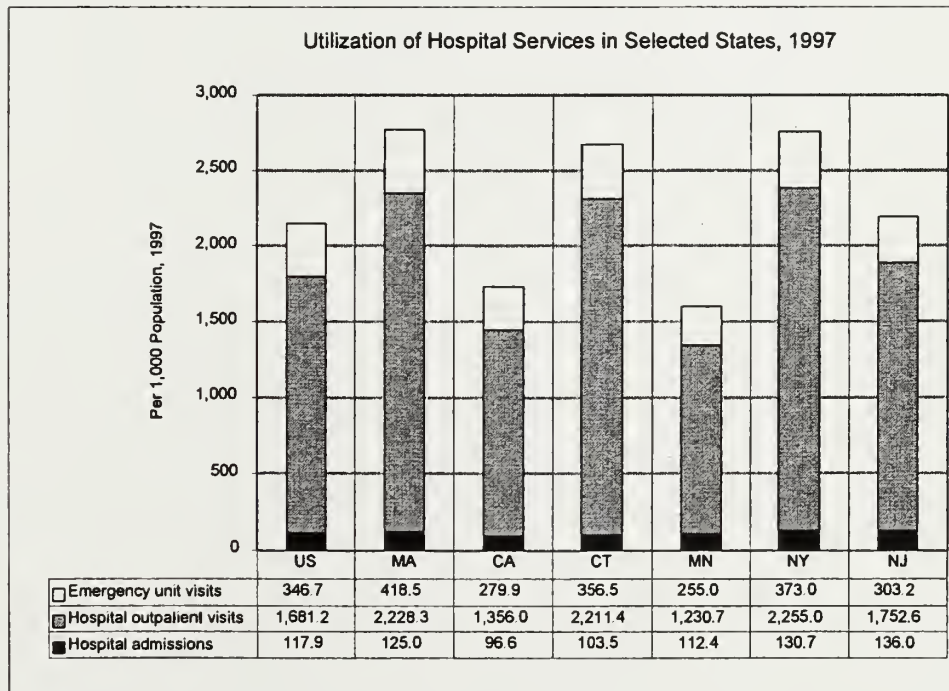
Figure 15:



Source: DHC FP 403 Cost Reports

- Outpatient visits have increased rapidly, while inpatient days decreased slightly.
- Inpatient discharges decreased from FY 93 to FY 96, but remained steady from FY 96 through FY 99.

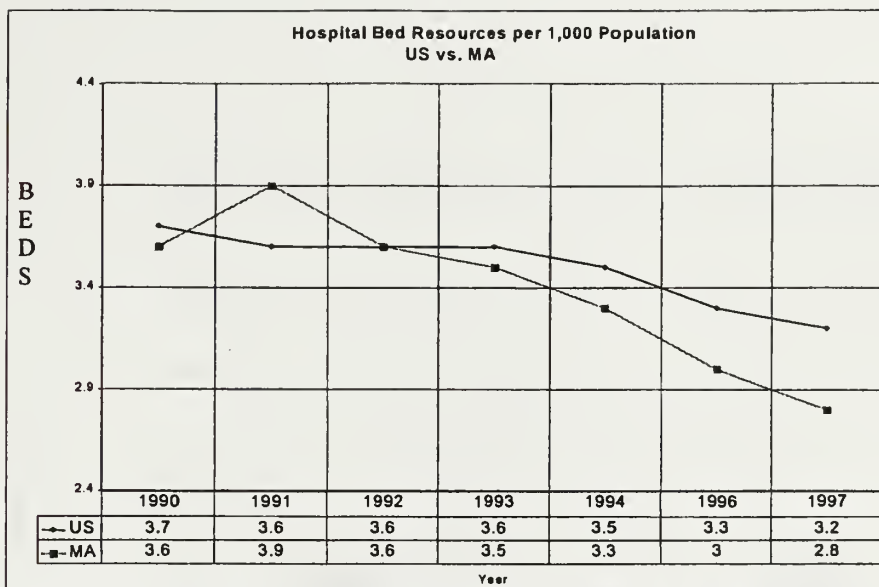
Figure 16:



Source: Reforming the Health Care System: State Profiles 1999, AARP ©1999

- Massachusetts utilization of inpatient hospital services is similar to the national average, and while outpatient clinic visits and emergency unit visits far exceeded the national average for those services.



**Figure 17:**

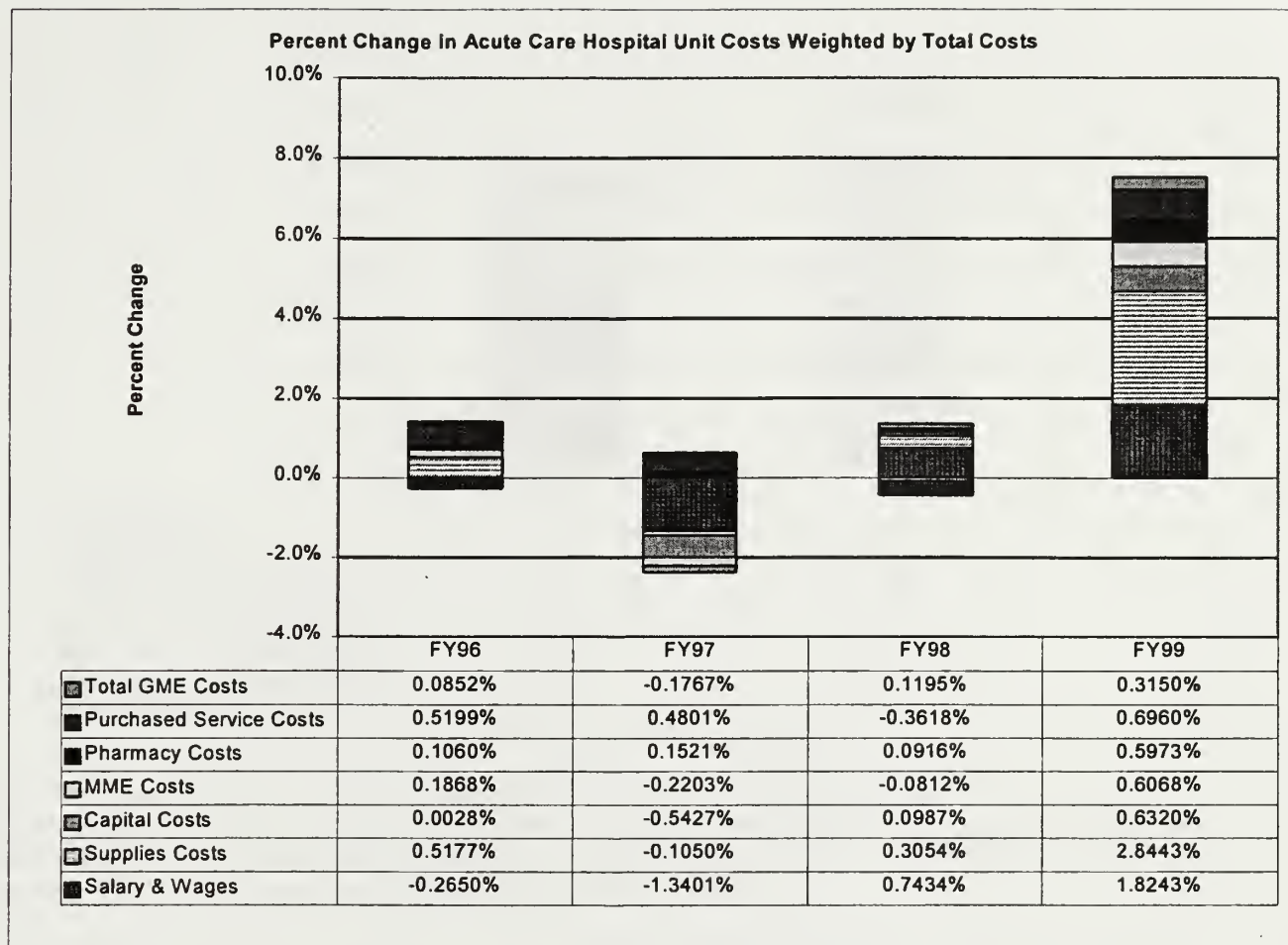
Note: Massachusetts data in this graph includes data from non-acute and state hospitals. Specifically, the definition of Hospital = all non-federal short-term general and other special hospitals, whose facilities and services are available to the public.

Source: US Department of Health and Human Resources

- Capacity in Massachusetts Hospitals fell below the national average in 1993, and has been decreasing more rapidly than in the US as a whole.



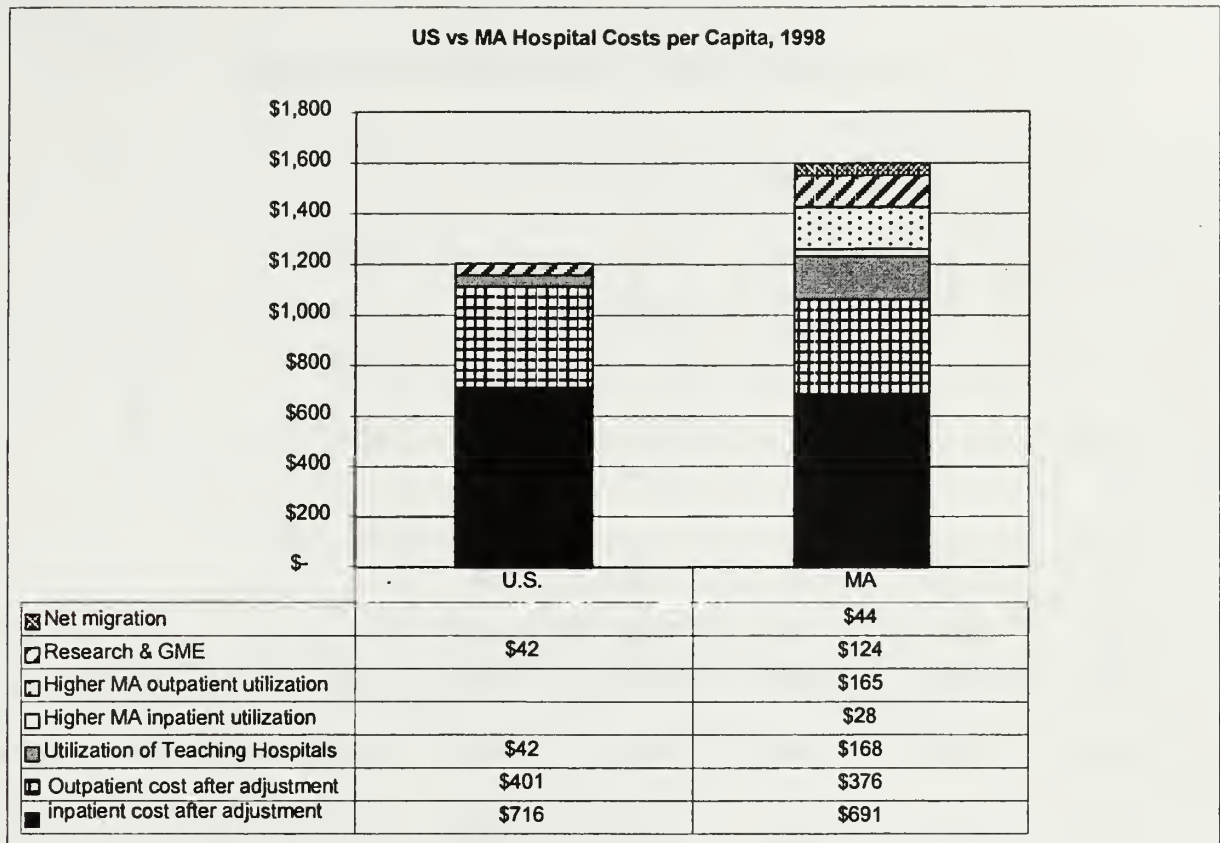
Figure 18:



Source: DHCFP 403 Cost Reports

- This graph shows the increases and decreases of the components of hospital costs from the previous fiscal year.
- In prior years, changes in hospital cost components fluctuated between increases and decreases. However, between FY98 and FY99, every cost component increased. Supplies and Salary and Wages costs represent the most dramatic increases.
- Percent change = component's percent change per inpatient day equivalent \* component's percent of total costs
- Inpatient day equivalent = inpatient days + (outpatient visits/2).
- Total percent changes in costs: FY 96 = 1.15%, FY97 = -1.75%, FY98 = 0.91%, FY99 = 7.51%.

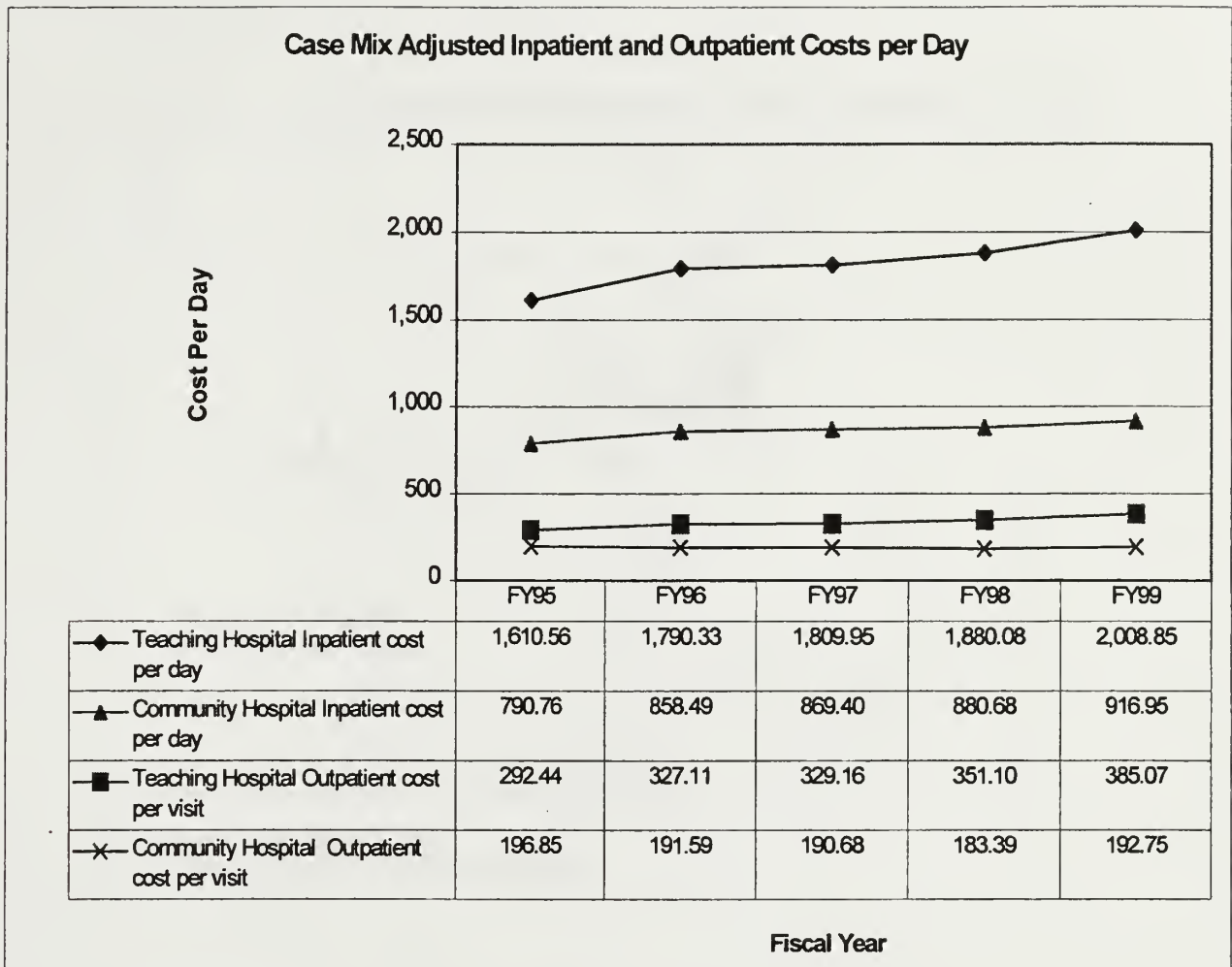


**Figure 19:**

*Sources:* American Hospital Association, *Hospital Statistics, 1998*; Reforming the Health Care System: State Profiles 1999, AARP © 1999; DHC FP-403 cost reports; U.S. Census data; *An Analysis of Massachusetts Hospital's Efficiency and Costs*, The Lewin Group; *A Study on the Condition of Massachusetts Community Hospitals and Prospects for the Future*, Massachusetts Council of Community Hospitals.

- Although Massachusetts has lower base inpatient and outpatient costs than the national average, its total per capita cost is higher than that of the US.
- The higher total per capita cost is largely due to higher utilization of outpatient services; more frequent use of teaching facilities, and higher research and education costs.



**Figure 20:**

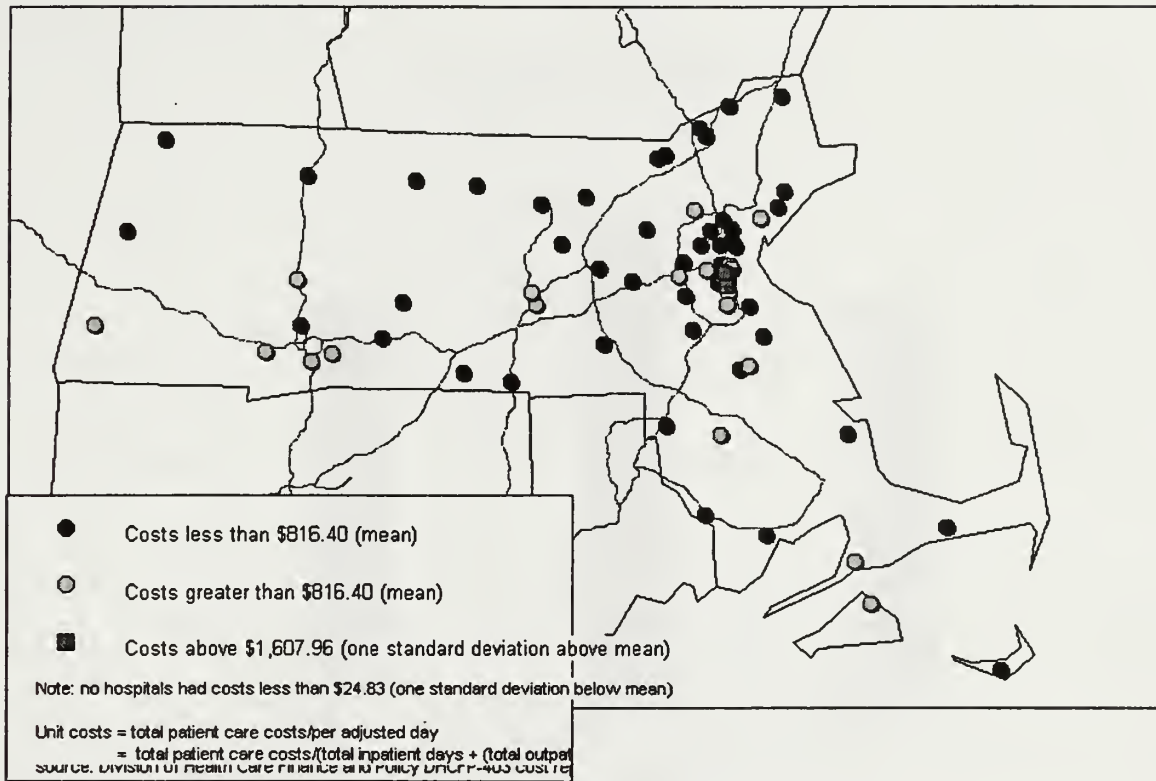
Source: DHCFP 403 Cost Reports

- The difference between inpatient costs at Teaching vs. Community Hospitals is much greater than the difference between their respective outpatient costs.



Figure 21:

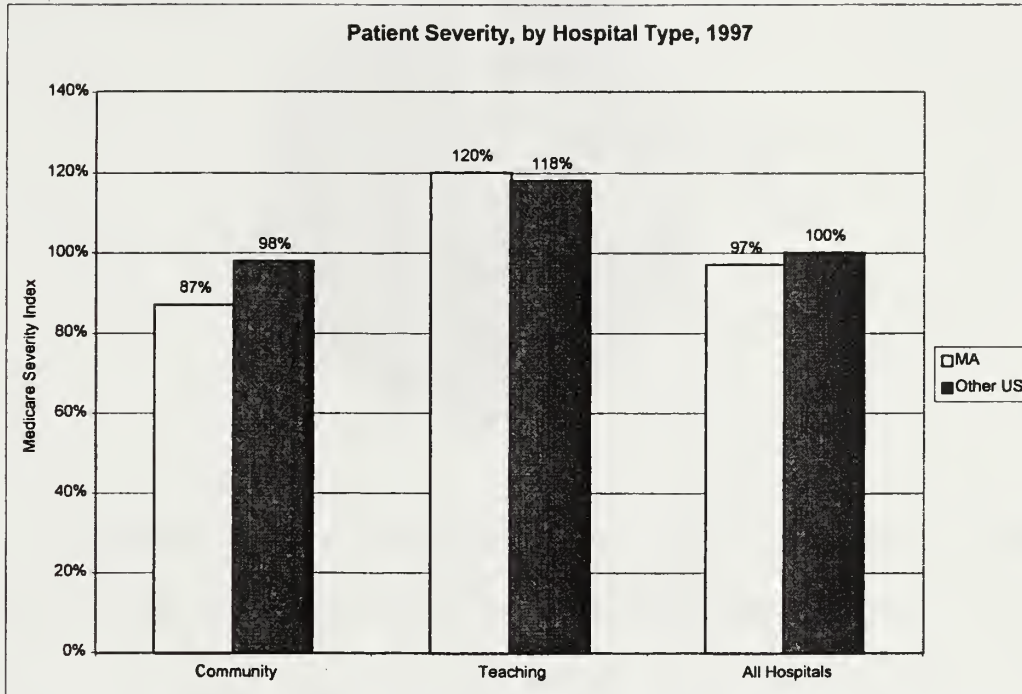
## Casemix Adjusted Unit Costs - FY98



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- Unit costs vary considerably across hospitals.

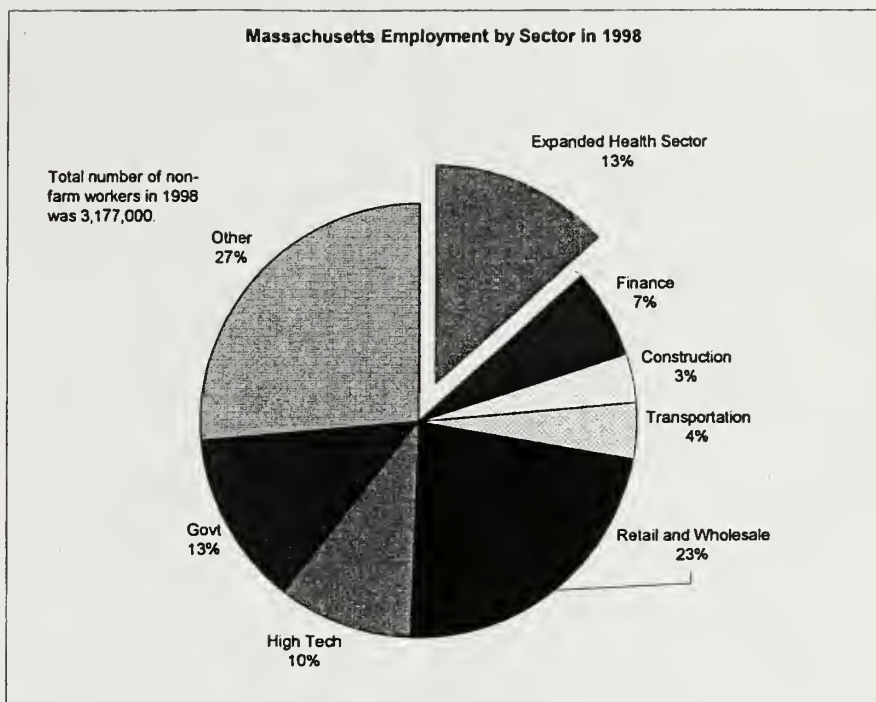


**Figure 22:**

Source: *Study on the Condition of Massachusetts Community Hospitals and Prospects for the Future*, Massachusetts Council of Community Hospitals

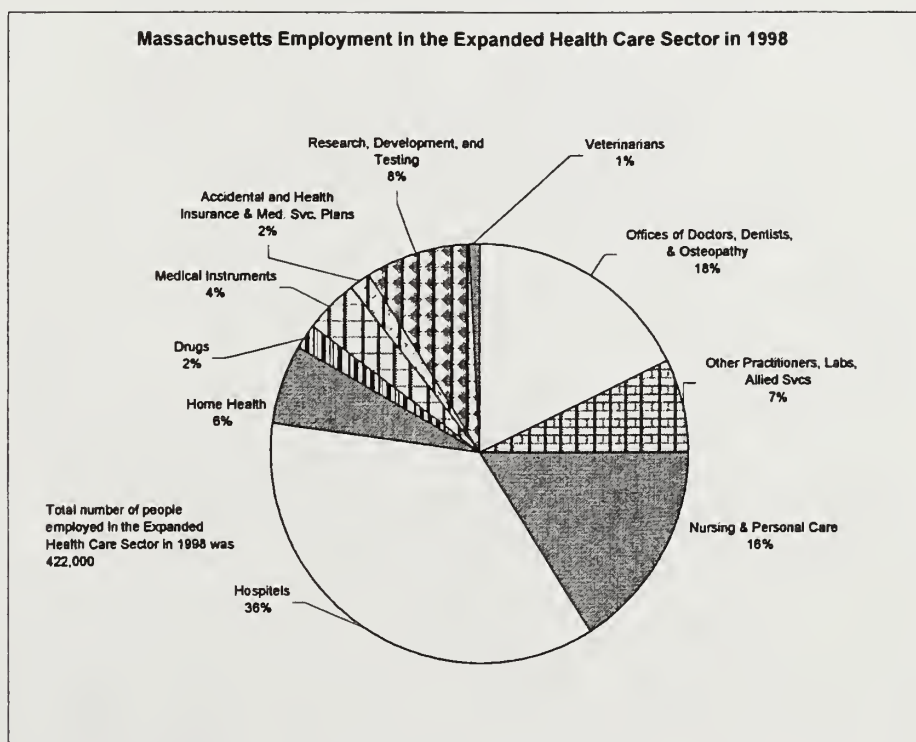
- The case mix at Massachusetts teaching hospitals is only slightly higher than the national average, despite the complex care provided to out of state patients. Massachusetts community hospitals have much lower case mix than community hospitals in the rest of the country.



**Figure 23:**

Source: Bureau of Labor Statistics, cited in *The Massachusetts Health Care Industry*, Standard & Poor, 2000

The expanded health care sector accounts for 13% of the state's employment.

**Figure 24:**

Source: Bureau of Labor Statistics, cited in *The Massachusetts Health Care Industry*, Standard & Poor, 2000

- Hospitals employ more than a third of the health care workers in Massachusetts.

